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	175517	A. BUILDING _____ B. WING _____	05/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation KS#74431.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This Requirement is not met as evidenced by:	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 157	Continued From page 1 The facility identified a census of 98 residents. The sample included 20 residents. Based on observation, record review, and interview the facility failed to notify 2 residents (#170 and #163) of changes in care and treatment. Findings included: - The Physician's Order Sheet (POS) for resident #170 signed 4/1/14 revealed the resident had diagnoses of right hip replacement and bronchitis (inflammation of the mucous membrane of the bronchial tubes). The Admission Minimum Data Set 3.0 (MDS) with an Assessment Reference Date (ARD) of 4/7/14 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 indicating he/she was cognitively intact, it was very important to the resident to have family or a close friend involved in discussions about care, and the resident participated in the assessment. The Care Area Assessment (CAA) for cognition and psychosocial well-being did not trigger. The medication care plan dated 4/9/14 with no review date revealed the resident or family were told of any medication changes. Record review revealed an order on 4/1/14 for physical and occupational therapy to evaluate and treat the resident, an order on 4/15/14 to discontinue the dressing to the resident's right hip and keep open to air, an order on 4/16/14 for a new medication to be given at bedtime for insomnia (inability to sleep), and an order on 4/17/14 for an antibiotic for dysuria (painful, burning urination usually caused by a bacterial infection or obstruction of the urinary tract). The	F 157		

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clinical record lacked documentation the resident or their representative were notified of these new orders.

Observation on 4/23/14 at 3:30 P.M. revealed licensed nursing staff NN followed up on the resident's request for pain medication and explained to the resident how the pain medication was ordered and scheduled.

Observation on 4/28/14 at 1:50 P.M. the resident walked in the hallway with staff assistance.

Interview on 4/22/14 at 3:35 P.M. with resident #170 revealed staff did not tell the resident about new orders when they were changed.

Interview on 4/28/14 at 10:05 A.M. with licensed nursing staff OO revealed residents were notified of new orders and should be charted in the nurses notes.

Interview on 4/28/14 at 3:22 P.M. with licensed nursing staff L, who worked day and evening shift, revealed residents were notified of changes in treatment but staff did not document notifications in the nurses notes.

Interview on 4/28/14 at 3:31 P.M. with licensed nursing staff N revealed the residents and their family were always made aware of changes in orders and staff charted notifications in the nurses' notes.

Interview on 4/28/14 at 3:50 P.M. with administrative nursing staff D revealed the nurses notified residents of all changes in treatment and that was charted in the nurses notes.

The facility failed to notify this resident of changes

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F 157	Continued From page 3 in care and treatment. - The Physician's Order Sheet (POS) for resident #163 dated 4/15/14 revealed the resident had diagnoses of acute respiratory failure, congestive heart failure (a condition when the heart output is low and the body becomes congested with fluid), and hypertension (elevated blood pressure). The Quarterly Minimum Data Set 3.0 (MDS) with an Assessment Reference Date (ARD) of 1/22/14 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14 indicating he/she was cognitively intact, had no behaviors, did not reject care and participated in the assessment. The Annual MDS 3.0 with an ARD of 4/12/14 revealed the resident had a BIMS score of 14 indicating he/she was cognitively intact, had no behaviors, did not reject care, and participated in the assessment. The Care Area Assessments for cognition, behaviors, and psychosocial well being did not trigger. The medication care plan updated 2/14/14 revealed the resident or his/her family were told of any medication changes. The clinical record revealed a new order on 2/18/14 for an antibiotic to treat pneumonia (inflammation of the lungs), a new order on 4/10/14 for a medicated powder to be applied to the resident's stomach three times a day, and an order on 4/18/14 for a treatment to the resident's heel to be done twice a day.	F 157		

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F 157	Continued From page 4 The record lacked documentation the resident or his/her family were notified of these orders. Observation on 4/23/14 at 9:30 A.M. the resident laid in bed watching television. Observation on 4/28/14 at 9:09 A.M. the resident laid in bed sleeping. Interview on 4/23/14 at 9:35 A.M. the resident stated the staff did not tell him/her about treatment changes but did tell his/her family member. Interview on 4/28/14 at 10:05 A.M. with licensed nursing staff OO revealed residents were notified of new orders and that was charted in the nurses' notes. Interview on 4/28/14 at 3:22 P.M. with licensed nursing staff L, who worked day and evening shift, revealed residents were notified of changes in treatment but staff did not document notifications in the nurses' notes. Interview on 4/28/14 at 3:31 P.M. with licensed nursing staff N revealed the residents and their family were always made aware of changes in orders and that was charted in the nurses' notes. Interview on 4/28/14 at 3:50 P.M. with administrative nursing staff D revealed the nurses notified residents of all changes in treatment and that was charted in the nurses notes. The facility failed to notify this resident of changes in care and treatment.	F 157		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES	F 248		

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F 248	Continued From page 5 The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This Requirement is not met as evidenced by: The facility reported a census of 98 residents. The sample included 20 residents. Based on observation, record review, and interview, the facility failed to provide activities for 2 (#59 and #36) of 3 residents reviewed for activities. Findings included: - The Admission Minimum Data Set (MDS) dated 4/6/14 for resident #59 revealed a Brief Interview for Mental Status (BIMS) score of 3 (severe cognitive impairment). It was very important to the resident to go outside when the weather was nice. The resident required extensive assistance of one person with bed mobility, transfers, walking in her/his room, and locomotion on the unit, and required limited assistance of one person with walking in the corridor. The resident used the device of a walker or wheelchair for mobility. The care plan dated 3/31/14 for activities revealed the resident enjoyed participating in some group activities, but her/his primary goal was to gain strength and stamina. Historically the resident enjoyed being with people, watching others, and engaged with activities when she/he desired. The resident enjoyed some group activities on occasion, and would continue to appreciate invitations to the same. Some of the resident's favorite group activities included listening to music, exercising, attending church	F 248		

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services, social groups, discussions, reading, and watching television (TV).

The Activity Assessment dated 3/31/14 revealed the resident enjoyed three or more group activities of interest per week which were mix and mingle, entertainment, and group discussions. Current interest consisted of community outings, family/friend visits, group discussions, mix and mingle, special events/parties, education, lectures, home town newspaper, puzzles/games, music, sign-alongs, worship services, exercise, animals/pets/outside, and humor.

The Resident Interview for Preferences for Customary Routine/Activities from the MDS 3.0 dated 3/31/14 revealed the resident felt it was very important to go outside to get fresh air when the weather was good. The resident enjoyed spending time resting in her/his room and activity staff would provide a calendar and encouraged the resident to join the activities of her/his interest.

Record review on 4/28/14 at 9:27 A.M. lacked documentation of activity notes or an activity log from 3/21/14 to present.

Observation on 4/24/14 at 8:49 A.M. revealed the resident's room lacked an activity calendar.

Observation on 4/24/14 at 2:51 P.M. revealed licensed nursing staff J obtained the resident's vital signs and did not encourage the resident to attend activities. Mix and mingle was scheduled to start at 3:00 P.M.

Observation on 4/24/14 at 3:06 P.M. revealed direct care staff Q changed the resident's bed linens and did not encourage the resident to

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attend activities. Mix and mingled started at 3:00 P.M.

Interview on 4/28/14 at 12:30 P.M. with activity staff AA stated she/he had not observed the resident in activities. Activity and nursing staff invited residents to activities. Activity staff and volunteers go room to room to provide residents the activity calendars.

Interview on 4/28/14 at 1:07 P.M. with direct care staff R stated the resident attended therapy and would not attend activities when encouraged. Nursing and activity staff invited the resident to activities and the activity calendar was provided by the activity staff.

Interview on 4/28/14 at 1:22 P.M. with licensed nursing staff K stated the resident attended therapy during the day and in the evenings attended the movies, and mix and mingle. Activity and nursing staff invited residents to attend activities. The activity calendar was provided to the residents by the activity department.

Interview on 4/28/14 at 2:52 P.M. with direct care staff S stated she/he was not sure which activities the resident attended as she/he was an as needed (PRN) nursing staff and activity and nursing staff invited residents to activities.

Interview on 4/28/14 at 3:34 P.M. with administrative nursing staff D stated nursing staff invited residents to activities and the resident's activity calendars were provided to the residents by the activity staff.

The policy and procedure dated 1/2008 titled Person Centered Life Enrichment Program Standards lacked documentation the facility staff

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would encourage residents to attend activities.

The clinical record lacked evidence the facility provided activities to meet this cognitively impaired dependent resident's mental, physical, and psychosocial needs.

- The Quarterly Minimum Data Set (MDS) dated 2/2/14 for resident #36 revealed a Brief Interview for Mental Status (BIMS) score 1 (severe cognitive impairment). The resident required extensive assistance of two plus (2+) persons with bed mobility and transfers, and required extensive assistance of one person with locomotion on the unit. The resident used a wheelchair for mobility.

The Resident Interview for Preference for Customary Routine and Activities from the MDS 3.0 dated 6/21/13 revealed it was very important for the resident to listen to the music she/he liked, be around animals, and somewhat important to do favorite activities and go outside to get fresh air when the weather was good. The resident continued to enjoy entertainment, music with "Maggie", Bingo and ice cream socials. She/he preferred to watch mystery shows in her/his room but appreciated reminders. She/he recently attended mix and mingle and the father's day beer garden, and the resident programs staff would continue to provide a monthly activity calendar and invite the resident to upcoming programs.

The Activity Progress Notes dated 2/2014 and untimed revealed the resident continued to prefer to watch her/his shows in her/his room and rest. Occasionally, the resident participated in musical entertainments or social events such as mix and

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mingle and ice cream socials. Activity staff would continue to stop by and visit.

The care plan dated 3/14/2014 listed the resident did not activity participate in most activity groups, but enjoyed being a part of them and enjoyed watching the people around him/her. The resident had a copy of the activity calendar in her/his room which was accessible and readable. The resident required assistance with ambulation to and from group activities, and verbal reminders to attend. When resting in her/his room, the resident enjoyed watching television (TV). Besides watching the news, the resident liked to watch combat movies, old movies, comedies, war documentary, Law and Order, criminal science investigation (CSI), and other detective shows. The resident enjoyed participating in the weekly ice cream social and loved to eat "Moose Tracks" ice cream or chocolate, enjoyed the cookies at the mix and mingles activity, musical entertainment, sometimes group games, loved dogs and pets 4 life visits, enjoyed watching the birds at the bird feeder each day outside her/his window which was installed and filled by family member, and would go outside, weather permitting, at lease once a week, either to sit in the sun or be part of a group. The resident enjoyed asking about the weather and looking out the window by her/his dining table.

Observation on 4/23/14 from 3:15 P.M. to 4:00 P.M. revealed the resident sat in a wheelchair and watched TV in her/his room and nursing and activity staff did not invite the resident to activities.

Observation on 4/24/14 at 3:36 P.M. revealed two nursing staff members entered the resident's room and did not encourage the resident to activities. The activity Mix and Mingle had started.

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F 248	Continued From page 10 Interview on 4/28/14 at 12:30 P.M. with activity staff AA stated she/he had not observed the resident in activities. Activity and nursing staff invited the residents to activities. Interview on 4/28/14 at 1:56 P.M. with direct care staff T stated the resident attended physical therapy and refused to attend activities when invited. Interview on 4/28/14 at 2:00 P.M. with licensed nursing staff H stated the resident did not like to attend activities when invited and stayed in her/his room to watch TV. Interview on 4/28/14 at 3:13 P.M. with direct care staff U stated the resident enjoyed listening to music, and nursing staff invited the residents to activities. Interview on 4/28/14 at 3:34 P.M. with administrative nursing staff D stated nursing staff invited residents to activities. The policy and procedure dated 1/2008 titled Person Centered Life Enrichment Program Standards lacked documentation the facility staff would encourage residents to attend activities. The facility failed to provide activities that met this cognitively impaired dependent resident's mental and psychological needs.	F 248		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate	F 278		

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F 278	Continued From page 11 each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This Requirement is not met as evidenced by: The facility identified a census of 98 residents. The sample included 20 residents. Based on observation record review and interview the facility failed to accurately asses and complete the Minimum Data Set (MDS) 3.0 assessment for 1 (#11) sampled resident Findings included: - Resident #11's April 2014 physician order sheet (POS) recorded the resident was admitted on 3/5/14 with diagnoses that included: personal history of falls, lack of coordination, malaise and fatigue (vague uneasy feeling of body weakness,	F 278		

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F 278	Continued From page 12 distress or discomfort). Review of the initial nurses' data sheet recorded the resident's weight was 108.6 pounds. The 5 day admission MDS assessment dated 3/12/14 documented the resident had a Brief Interview For Mental Status score of 15 which indicated his/her cognition was intact. The MDS recorded the resident required supervision with meals. The MDS identified the resident weighed 109 pounds. The MDS indicated "no or unknown" to whether the resident had a 5 percent weight loss/gain in the previous one month or 10 percent loss/gain in the previous 3 months. The 14 day MDS assessment dated 3/19/14 recorded the resident weighed 100 pounds. The resident had a 8.25 percent weight loss since the 3/12/14 MDS. The MDS indicated "no or unknown" to whether the resident had a 5 percent weight loss/gain in the previous one month. The 30 day MDS assessment dated 4/2/14 recorded the resident weighed 97 pounds. The resident had a 11 percent weight loss since the 5 day MDS completed on 3/12/14. The MDS indicated "no or unknown" to whether the resident had a 5 percent weight loss/gain in the previous one month. The 3/6/14 nutrition Care Area Assessment (CAA) did not trigger for review. On 4/22/14 at 12:00 noon observation revealed the resident at lunch, consumed 50 percent of his/her meal and staff did not offer encouragement and/or extra food items. On 4/28/14 at 3:30 P.M. administrative licensed	F 278		

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F 278	Continued From page 13 nurse D stated staff were to follow the Resident Assessment Instrument (RAI) manual and acknowledged the MDS was incorrect. The Medi-Pass Resident Assessment Instrument User Manual Version 3.0, revised May 2013 documented, Page K-5 For subsequent Assessments, From the Medical record, compare the resident weight in the current observation period to his/her weight in the observation period 30 days ago. If the current weight was less than the weight in the observation period 30 days ago calculate the percentage of weight loss. The facility failed to develop a comprehensive MDS assessment which accurately reflected this resident's weight loss.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		

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This Requirement is not met as evidenced by:
The facility identified a census of 98 residents. The sample included 20 residents. Based on observation, record review, and interview the facility failed to develop individualized and comprehensive care plans for 2 residents of the sample, #11 for nutrition and weight loss and #210 for hospice care.

Findings included:

- Resident #11's April 2014 physician order sheet (POS) recorded the resident admitted on 3/5/14 with diagnoses that included: a personal history of falls, lack of coordination, malaise and fatigue (vague uneasy feeling of body weakness, distress or discomfort).

The 5 day admission Minimum Data Set 3.0 (MDS) assessment dated 3/12/15 documented the resident had a Brief Interview For Mental Status score of 15 which indicated his/her cognition was intact. The MDS recorded the resident required extensive assistance of one staff member with bed mobility and transfers, limited assistance with walking on and off the unit, toilet use, dressing, and personal hygiene and received supervision with meals. The MDS identified the resident received diuretic medications (a medication to remove excess fluid from the body), was 5 feet in height, weighed 109 pounds, and received a regular diet.

The 3/6/14 nutrition Care Area Assessment did not trigger for review.

The resident's revised care plan dated 3/12/14 directed staff to provide care with activities of

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F 279	Continued From page 15 daily living (ADLs) in effect, bathing, toilet use, dressing etcetera, fall risk, pressure sore risk, bowel and bladder incontinence, and medications use. The resident's revised care plan dated 3/12/14 did not address the residents nutritional needs, food likes or dislikes, supplement use, and/or weight loss status. Review of the resident's weight record revealed: 3/5/14 - 108.6 pounds, 3/10/14 - 102.2 pounds, 3/17/14 - 100.2 pounds, 3/22/14 - 99.4 pounds, 3/30/14 - 97 pounds, 4/7/14 - 99.6 pounds, 4/14/14 - 101.4 pounds, 4/19/14 - 100.8 pounds. On 4/22/14 at 12:00 noon observation revealed the resident was at lunch, consumed 50 percent of his/her meal and staff did not offer encouragement and/or extra food items. Interview on 4/28/14 at 3:00 P.M. administrative licensed nurse D stated staff were expected to care plan areas which indicated a potential problem or concern. The 2008 Care Planning-Interdisciplinary Team facility policy recorded Our facility's Care planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident. The facility failed to identify, and develop a care plan for nutritional interventions to prevent weight loss for this resident at risk for nutritional problems.	F 279		

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- The Physician's Order Sheet (POS) for resident #210, dated 4/15/14 revealed diagnoses of Chronic Obstructive Pulmonary Disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) and failure to thrive (a condition in which people fail to gain weight and may lose weight).

The significant change Minimum Data Set 3.0 (MDS) with an Assessment Reference Date (ARD) of 1/8/14 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 6 indicating the resident was severely impaired cognitively. The resident did not have a condition or chronic disease that may result in a life expectancy of less than 6 months, received hospice care while a resident, had no pain medications or pain, and had shortness of breath with exertion and while lying flat.

The Care Area Assessment (CAA) for psychosocial well-being dated 1/14/14 revealed the resident had a history of depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) and received Celexa (a medication to treat depression), was alert and oriented with intermittent confusion to time and situation, was able to make his/her needs known, was in good spirits and cooperative with staff, received meals in the main dining room, and was social with his/her peers.

The Quarterly MDS 3.0 with an ARD of 3/30/14 revealed the resident had a BIMS of 6 indicating he/she was severely impaired cognitively. The resident had no pain medication, did not have

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pain or shortness of breath, received hospice while a resident and did not have a condition or chronic disease that may result in a life expectancy of less than 6 months.

The facility's care plan for hospice dated 12/24/13 with a revision date of 2/12/14 revealed the resident was admitted to the facility on hospice. Hospice was contacted as needed regarding any change in his/her status, for medications, pain issues, worsening psychosocial status, upon death, and prior to ordering labs or X-ray or before sending the resident to the hospital. Hospice provided many of the resident's medications. Facility staff reported signs and symptoms of pain to the hospice nurse, provided family and resident support throughout the dying process, reported changes or care decisions to the responsible party, assisted the resident to remain clean, dry, and pain free, maintained his/her dignity and comfort, and offered fluids and foods. The hospice aide visited twice a week and provided supplemental baths. The hospice nurse visited 1 time a week and stayed in touch with the family regarding the resident's condition. The hospice social worker visited and assessed the needs of the family and the resident. The hospice spiritual counselor visited and assessed the need for spiritual support for the family and the resident. Facility staff assessed the resident for signs and symptoms of pain or air hunger and notified the hospice nurse or physician. If the resident was restless, facility staff consulted the resident's current Medication Administration Record (MAR) for something to help with anxiety (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) or contacted hospice.

On 4/24/14 at 9:15 A.M. direct care staff O took

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the resident to the bathroom and transported him/her to bed.

On 4/23/14 at 4:58 P.M. the resident sat at the dinner table in his/her wheelchair waiting for dinner.

Interview on 4/28/14 at 9:23 A.M. with direct care staff LL, who typically worked night shift, revealed he/she received information about the resident's care from a jot sheet (a paper with information about each resident used by the facility staff to direct the care provided to the residents), he/she was unaware how often the hospice staff came to see the resident, information about the care hospice provided to the resident was not on the jot sheet, and hospice provided all supplies needed for the resident.

Interview on 4/28/14 at 9:51 A.M. with direct care staff MM revealed he/she had not seen hospice staff in the facility providing care for the resident, the resident's oxygen concentrator was provided by hospice, and the facility provided all other supplies for the resident.

Interview on 4/28/14 at 3:05 P.M. with direct care staff Z revealed hospice came to see the resident occasionally on the evening shift but he/she was unaware of how often they were at the facility and hospice provided all the resident's supplies including briefs, wipes, and gloves.

Interview on 4/28/14 at 2:18 P.M. with licensed nursing staff H revealed the hospice aide came to see the resident once a week, gave him/her a bath, and did his/her daily hygiene, the facility gave the resident one bath a week and the hospice aide gave him/her one bath a week, and hospice did not supply any of the resident's

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F 279	Continued From page 19 medications. Interview on 4/28/14 at 3:22 P.M. with licensed nursing staff L revealed hospice came to the facility once or twice a week but that varied, hospice did not provide any of the resident's medications, hospice provided the resident's wheelchair and oxygen concentrator, and all other supplies were provided by the facility. Interview on 4/28/14 at 3:50 P.M. with administrative nursing staff D revealed hospice and the pharmacy knew who provided which medications for the resident and would not send out medications if it was a medication they were not responsible for, and he/she was not aware if all services provided by hospice were on the care plan but the information was on the hospice contract. The policy for comprehensive care plans revised in October 2010 provided by the facility revealed an individualized comprehensive care plan was developed for each resident. The facility failed to have a comprehensive hospice care plan for this resident who received hospice services.	F 279		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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F 323	Continued From page 20 This Requirement is not met as evidenced by: The facility identified a census of 98 residents. The sample was 20 residents. Based on observation, record review and interview, the facility failed to provide interventions as planned for one (#113) of 3 residents reviewed for falls. Findings included: - The signed physician's order sheet dated 3/28/14 revealed resident #113 had diagnoses of chronic back pain and falls. The admission Minimum Data Set (MDS) dated 3/6/14 revealed the resident had moderately impaired cognition, had physical behaviors, needed extensive assistance for bed mobility, transfer, locomotion, dressing, and toilet use, personal hygiene required 2 person assistance, had a history of falls, had a pressure reducing device for chair, had occupational therapy (OT) 6 out of 7 days, physical therapy (PT) 5 out of 7 days, was not steady, only able to stabilize with staff assist, and used a wheelchair. The CAA for falls dated 3/10/14 revealed the resident was at increased risk for further falls. The factors included dementia, incontinence, weakness, depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), overall physical and mental decline, Parkinsons (slowly progressive neurological disorder characterized by resting tremor, rolling of the fingers, mask-like faces, shuffling gait, muscle rigidity and weakness), and he/she received an antidepressant daily. The resident had no falls since admission, and received skilled PT and OT to help improve his/her strength and endurance. The resident slept in a low bed for fall protection.	F 323		

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The fall care plan dated 4/18/14 at 7:30 P.M. revealed staff found the resident on the floor next to his/her bed. He/she was in his/her wheelchair prior to the fall and stated he/she slid from his/her wheelchair to the floor. Staff reported the resident had no injuries, interventions included a medication review with no recent changes, a personal alarm on at all times, to continue to work with therapy for strengthening, a low bed, and a mat on the floor next to the bed.

The nurse's note dated 4/24/14 and untimed, revealed the staff found the resident on the floor in the dining room. The resident stated he/she was trying to get up and move to a different table. No injury was found on assessment and neurological assessment was within normal limits. New interventions of hipsters and a scheduled toileting program were started.

The revised care plan for falls dated 4/24/14 at 11:30 A.M. revealed neurological assessments (an assessment preformed to detect neurological dysfunction) were started, he/she wore hipsters (undergarment with padding for the hip bones), a 72 hour bowel and bladder assessment to be completed, continue to work with therapy, use of a low bed, floor mat beside the bed, and a personal alarm.

The nurse's note dated 4/27/14 at 11:24 P.M. revealed the resident tried to get up unattended several times, the certified nurse aide (CNA) watched the resident closely, the chair alarm was in place, and the resident sat in the wheelchair by the nurses' desk.

On 4/28/14 at 8:31 A.M. the CNA Jot sheet (listed instructions for the CNA's to provide cares for the

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resident) revealed the resident had a low bed, personal alarm on at all time, and mats by his/her bed. The CNA Jot sheet lacked documentation for the resident to wear hipsters.

Observation on 4/23/14 at 4:10 P.M. the resident sat in the wheelchair with a personal alarm attached while the resident's family wheeled the resident down the hall.

On 4/28/14 at 8:19 A.M. the resident sat at the dining room table with the personal alarm attached. At 8:23 A.M. there was a new package of hipsters on the resident's bedside table, the bed was in the low position, and a floor mat beside the bed.

Interview on 4/24/14 at 11:25 A.M. the resident stated he/she was trying to get from one table to another to change seats and thought he/she could take the 2 steps without having to ask for help, his/her foot slipped out from under him/her even with shoes on. The staff told him/her to ask for help but he/she did not ask for help before falling on this day.

On 4/24/14 at 11:34 A.M. direct care staff V said the resident had a personal alarm, low bed, and floor mat.

On 4/24/14 at 3:44 P.M. direct care staff W said the resident had a low bed, mat on the floor and an alarm for fall preventions.

On 4/28/14 at 8:24 A.M. direct care staff X said he/she was not sure if the resident wore hipsters.

On 4/28/14 at 8:29 A.M. direct care staff Y said the hipsters were not on the resident at that time, his/her Jot sheet revealed hipsters were not listed

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F 323	Continued From page 23 for this resident. On 4/28/14 at 8:25 A.M. licensed staff L said hipsters should be on the resident now. The resident's fall interventions included a bed alarm, a chair alarm, a low bed, staff checked on the resident every 2 hours for incontinence, and the resident wore hipsters. On 4/28/14 at 8:32 A.M. licensed staff M stated the resident should wear hipsters and licensed staff would add this information to the CNA's Jots sheets when it was added to the care plan on 4/24/14. On 4/28/14 at 8:52 A.M. administrative nursing staff D said interventions were put into place immediately after a resident fell, and would expect the hipsters to be on the resident immediately on 4/24/14 when entered on the care plan. The facilities undated policy for using the care plan revealed the nurse supervisor used the resident's care plan to complete the CNA's daily work assignment sheets. The facility failed to put fall interventions into place as planned for this cognitively impaired resident at high risk for falls.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and	F 325		

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F 325	Continued From page 24 (2) Receives a therapeutic diet when there is a nutritional problem. This Requirement is not met as evidenced by: The facility identified a census of 98 residents. The sample included 20 residents of which 3 were reviewed for nutrition. Based on observation, record review, and interview the facility failed to monitor the percentage intake of supplements for 1 (#243) resident of the sample. Findings included: - The closed record review of resident #243 revealed the signed physician's order sheet dated 1/3/14 listed the diagnoses of Chronic Obstructive Pulmonary Disease (COPD - progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and acute respiratory failure (a disease characterized by a relatively sudden onset of symptoms that are usually severe). The admission Minimum Data Set (MDS) dated 1/10/14 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 which revealed the resident was cognitively intact, had a poor appetite 2 to 6 days, of 7 days in the look back period, needed supervision for setup with eating, had no swallowing or nutrition problems, was on a therapeutic diet, had no unknown weight loss or gain, had no oral or dental problems, received insulin, antianxiety, antidepressant, anticoagulant, and antibiotic medications, and he/she did not receive restorative services for eating or swallowing.	F 325		

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The Care Area Assessment dated 1/15/14 for Activities for Daily Living (ADL) function revealed the resident was alert and orientated and was able to make his/her needs known, required limited assistance from staff, was on a consistent carbohydrate with no added salt diet, and was independent with eating after set up assist if needed.

The Care Area Assessment dated 1/13/14 for nutrition revealed the resident received a consistent carbohydrate with no added salt therapeutic diet, was able to feed him/herself, and was able to communicate his/her needs and concerns to staff. The registered dietician monitored the resident for his/her needs. The plan was to improve his/her nutritional status as evidenced by stable weight, adequate meal and fluid intakes, and improved lab values.

The undated care plan for ADLs revealed the resident was independent with eating after set-up. Staff offered choices from the menu in the dining room, which was on each dining table, and the resident was able to manage at mealtime. If he/she did not like anything on the menu, staff offered alternative choices. Staff monitored the resident's weights weekly and with any significant weight loss or gain and staff reported to the physician. If he/she needed a planned weight change program, the dietician was consulted.

The undated skilled therapy services for COPD revealed staff conducted a weekly interdisciplinary meeting to discuss his/her progress with nutritional needs.

The untimed physician order dated 1/13/14 revealed an order for a high calorie supplement of 2.0 at 120 cubic centimeters (cc) by mouth twice

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F 325	Continued From page 26 a day for weight loss. On 4/28/14 at 2:29 P.M. record review and interview with administrative nursing staff D revealed a lack of staff documentation for percent (%) of the supplement consumed by the resident. The weight record revealed: 1/3/14 - 155 pounds 1/6/14 - 145 pounds 1/11/14 -144.2 pounds. The untimed nurse's note dated 1/9/14 revealed staff provided the resident his/her bedtime protein snack. The clinical record lacked the percentage of the supplement the resident consumed. The nutritional risk review dated 1/13/14 revealed the resident weighed 145 pounds, had a consistent carbohydrate with no added salt diet, a nutritional supplement order for 2 cal 120 cc twice a day, had an upper partial, oral intake met 50 to 75% of estimated needs, lost greater than 7.5% in 3 months, had no oral function problems, ate independently in the dining room, had weight loss related to recent weakness and hospitalization for COPD, heart disease, diabetes, use of hypoglycemic agents, laxatives, steroids, psychotropic and antibiotics medications. Noted weight loss after admission, supplements were in place, and continue plan of care. The untimed dietary progress note dated 1/13/14 revealed the resident received a regular consistent carbohydrate with no added salt diet, he/she was able to feed him/herself and was able to communicate his/her needs. His/her usual weight was 165 pounds, had some weight loss in the past few months, and continued to have weight loss. He/she expended more calories than	F 325		

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F 325	Continued From page 27 consumed due to his/her COPD. The dietician suggested the resident receive a supplement of 2.0, 120 cc twice a day for added nutrition. On 4/28/14 at 5:47 P.M. direct care staff Z said the certified nurse aides (CNA) passed snacks to the residents after 8:00 P.M. and charted in the computer how much the residents consumed. On 4/28/14 at 5:49 P.M. licensed staff N said the 2.0 nutritional supplements were listed on the medication administration record and staff documented the percentage the resident consumed. On 4/28/14 at 2:29 P.M. administrative nursing staff D said he/she expected staff to document the amount of the nutritional supplement consumed by the resident. The facility's nutrition (Impaired)/Unplanned Weight Loss- Clinical Protocol dated April 2013 lacked interventions for the monitoring of nutritional supplements. The facility failed to monitor percentage intake for the nutritional supplements for this resident.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329		

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F 329	Continued From page 28 Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This Requirement is not met as evidenced by: The facility identified a census of 98 residents. The sample included 20 residents. Based on observation, record review, and interview, the facility failed to care plan and accurately monitor the use of anti-coagulant medication for 1 (#351) of 6 residents sampled for medication review. Findings included: - Resident #351's April 2014 physician order sheet (POS) recorded the resident admitted on 3/20/14 with a diagnoses of Cardiovascular accident (CVA-stroke, the sudden death of brain cells due to lack of oxygen when the blood flow to the brain was impaired by blockage or rupture of an artery to the brain). The 14 day Minimum Data Set (MDS) assessment dated 4/3/14 recorded the resident required limited assistance of one staff member with most activities of daily living (ADLs) in effect, toilet use, bathing, dressing, and walking. The MDS recorded the resident was continent, had no	F 329		

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F 329	Continued From page 29	F 329		

falls, and received anti-coagulant (blood thinning) medication.

Review of the clinical record revealed the resident admitted to the facility with a physician's order for 1 milligram of Coumadin (anti-coagulant medication) every day and orders for labs to monitor the medication.

Continued review of the POS revealed the physician made dose adjustments to the medications and the most recent order on 4/21/14 was to increase the Coumadin to 6 milligrams every day.

The revised care plan dated 3/27/14 lacked documentation to indicate the resident received the anti-coagulant medication, Coumadin, that had a Black Box Warning (BBW-a medication noted by the Food and Drug Administration (FDA) to have potentially life threatening side effects).

According to www.fda.gov, Coumadin contained a Black Box Warning of bleeding risk. Coumadin could cause major or fatal bleeding. Monitor labs regularly in all treated patients. Drugs, dietary changes, and other factors affect International Normalized Ration(INR) levels achieved with Coumadin therapy.

On 4/23/14 at 3:45 P.M. observation revealed the resident walked with physical therapy's assistance and used a cane in his/her left hand.

Interview on 4/28/14 at 3:00 P.M. administrative licensed nurse D stated he/she expected staff to care plan areas, which indicated a potential problem or concern.

The Care Plan-Comprehensive revised 2008

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F 329	Continued From page 30 facility policy lacked documentation to address medications specifically however, staff were to care plan risk areas associated with identified problems. The facility failed to monitor for the BBW side effects of Coumadin.	F 329		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This Requirement is not met as evidenced by: The facility identified a census of 98 residents, with one central kitchen and 4 kitchenettes. Based on observation, interview, and record review the facility failed to provide food prepared by methods that conserved flavor and appearance and was palatable, attractive, and at the proper temperature. Findings included: - Observation on 4/24/14 at 12:50 P.M. of a test tray from the kitchenette on Piedmont 2 revealed soup that was bland, chicken stroganoff that was bland and did not look appetizing, and a plate that had no variety of color and did not look appetizing. A test tray from Tuscany 1 revealed chicken stroganoff that did not look appetizing and tasted bland, pizza that was 133.5 degrees Fahrenheit (F), zucchini that was 126 degrees F, brown in color, and did not look appetizing, and carrot soup that tasted bland. The pureed tray provided to Tuscany 1 revealed pizza at 133	F 364		

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F 364	Continued From page 31 degrees F, zucchini at 130 degrees F, and soup at 128 degrees F. Observation on 4/23/14 at 11:00 A.M. in the main kitchen revealed tator tots at 135 degrees F. Interview on 4/22/14 at 10:00 A.M. with dietary staff DD revealed the temperatures of foods were completed in the main kitchen, and again before serving in the kitchenettes. Confidential interviews during stage 1 of the survey on 4/22 and 4/23/14 revealed multiple residents stated the food did not taste good, did not look appetizing, was not served hot, soup was always cold, and/or was too spicy. Interview on 4/28/14 at 3:45 P.M. with dietary staff DD revealed he/she did the menu planning and had color in mind when planning. He/she tried to get 2 or 3 colors on the plate and added garnish to give some extra color for attractiveness and appeal. He/she also put a display plate out for dietary aides in the kitchenettes to know how he/she expected the plates to look. The undated food temperatures policy provided by the facility revealed foods should be served at proper temperatures to ensure food safety and palatability. The facility failed to serve palatable, attractive food at the proper temperature.	F 364		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local	F 371		

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F 371	Continued From page 32 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This Requirement is not met as evidenced by: The facility identified a census of 98 residents served from 1 central kitchen to 4 kitchenettes. Based on record review, observation, and interview, the facility failed to store food under sanitary conditions and at appropriate temperatures, and clean dishes and utensils under sanitary conditions in 3 of 4 kitchenettes, and failed to have appropriate drainage of the ice makers in 3 of 4 kitchenettes for 2 or 4 days on site. Findings included: Observation of the walk in cooler in the main kitchen on 4/22/14 at 9:58 A.M. revealed open, undated plastic storage bags of sliced tomatoes, lettuce, and onions, and cheese slices partially wrapped in plastic wrap, sat in a pan with pickle juice covering the bottom. Observation on 4/22/14 at 10:25 A.M. in the kitchenette on Piedmont 1 revealed 3 broken thermometers rested in the refrigerator, and one thermometer that read 54 degrees Fahrenheit (F). A large amount of crumbs were noted between the ledges of the oven. At 10:50 A.M. a new thermometer placed in the refrigerator revealed a temperature of 41 degrees F. Observation on 4/22/14 at 10:33 A.M. in the kitchenette on Piedmont 2 revealed the rinse	F 371		

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F 371	Continued From page 33	F 371		

temperature for the dishwasher was 137 degrees F. A second run of the dishwasher at 10:42 A.M. revealed a rinse temperature of 170 degrees F. A large amount of crumbs were noted between ledges of the oven.

Observation on 4/22/14 at 10:52 A.M. in the kitchenette on Tuscany 2 revealed a large amount of crumbs between the ledges of the oven and the floor was sticky.

Observation on 4/22/14 at 10:57 A.M. in the kitchenette on Tuscany 1 revealed a refrigerator temperature of 48 degrees F. A glass of orange juice revealed a temperature of 47.7 degrees F. At 11:05 A.M. the rinse temperature of the dishwasher was 172 degrees F. A second run of the dishwasher at 11:08 A.M. revealed a rinse temperature of 178 degrees F.

Observations on 4/22/14 between 1:30 P.M. and 2:00 P.M. revealed ice machines on Piedmont 1 and 2, and Tuscany 1 did not have air gaps.

Observation on 4/23/14 at 10:13 A.M. in the Piedmont 2 kitchenette revealed a dishwasher rinse temperature of 166 degrees.

Record review of refrigerator logs from 3 of the 4 kitchenettes from 2/1/14 to 4/8/14 revealed days where temperatures exceeded 41 degrees F or the temperatures were not recorded.

Record review of the dishwasher logs from 2/1/14 to 4/20/14 from 3 of the 4 kitchenettes revealed logged wash temperatures did not consistently reach 150 degrees F, and rinse temperatures did not reach 180 degrees F or were absent.

Interview on 4/22/14 at 9:51 A.M. with dietary

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F 371	Continued From page 34 staff DD revealed the the dishwashers in the kitchenettes were high temperature washers and were checked after each meal. Interview on 4/22/14 at 10:00 A.M. with dietary staff DD revealed it was the policy of the facility to date and cover food products when opened. Interview on 4/22/14 at 10:28 A.M. with dietary staff FF revealed he/she checked refrigerator temperatures before every meal. Interview on 4/22/14 at 10:39 A.M. with dietary staff DD revealed if dietary staff got a low temperature on the dishwasher they ran it again with a temperature strip. He/she acknowledged the temperature testing strip only verified the water was above 160 degrees. Interview on 4/22/14 at 10:52 A.M. with dietary staff DD revealed floors and all other surfaces were cleaned after every meal and were checked by management staff at the end of every shift and that dietary preformed a cleaning duty at the end of every shift such as deliming the wells in the dish washer, cleaning the coffee machine, cleaning the oven, and cleaning the inside and outside of the trash cans. Interview on 4/22/14 at 10:57 A.M. with dietary staff DD revealed refrigerator temperatures were to be below 41 degrees and products were to be shelved in the refrigerator in a way that allowed air circulation. Interview on 4/22/14 between 1:30 P.M. and 2:00 P.M. with maintenance staff BB revealed he/she acknowledged the ice machines did not have air gaps.	F 371		

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F 371	Continued From page 35 Interview on 4/23/14 at 10:10 A.M. with dietary staff EE revealed dishwasher and refrigerator temperatures were checked after each meal, refrigerator temperatures were to be below 40 degrees, wash temperatures were to be at least 160 degrees, and rinse temperatures at least 185 degrees. The Storage of Perishable Food policy last revised on 5/2010 provided by the facility revealed perishable food must be refrigerated in a manner that optimized food safety, nutrient retention, and aesthetic quality. Refrigerators were maintained at a temperature of 32-40 degrees Fahrenheit or below, refrigerated items were covered, and labeled indicating the product name, and dated, and food was stored loosely to facilitate circulation of cold air. The Washing and Sanitizing Dishes policy last revised 5/2010 provided by the facility revealed all dishes and utensils were washed and sanitized using appropriate machine washing procedures and that for high temperature dish machines the wash water temperature must be a minimum of 150 degrees F and the rinse water must reach 180 degrees F. The facility failed to store foods under sanitary conditions and at appropriate temperatures and to clean dishes and utensils under sanitary conditions and temperatures.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to	F 428		

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F 428	Continued From page 36 the attending physician, and the director of nursing, and these reports must be acted upon. This Requirement is not met as evidenced by: The facility identified a census of 98 residents. The sample included 6 residents. Based on observation, record review, and interview, the consultant pharmacist failed to recognize the facility did not monitor for the Black Box Warning for the use of anti-coagulant medication for 1 (#351) of 6 residents sampled for medication review. Findings included: - Resident #351's April 2014 physician order sheet (POS) recorded the resident was admitted on 3/20/14 with a diagnoses of Cardiovascular Accident (CVA - stroke, the sudden death of brain cells due to lack of oxygen when the blood flow to the brain was impaired by blockage or rupture of an artery to the brain). The 14 day Minimum Data Set (MDS) assessment dated 4/3/14 recorded the resident required limited assistance of one staff member with most activities of daily living (ADLs) in effect, toilet use, bathing, dressing, and walking. The MDS recorded the resident was continent, had no falls, and received anti-coagulant (blood thinning) medication. Review of the clinical record revealed the resident admitted to the facility with a physician's order for 1 milligram of Coumadin (anti-coagulant medication) every day and orders for labs to	F 428		

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F 428	Continued From page 37 monitor the medication. Continued review of the POS revealed the physician made dose adjustments to the medications and the most recent order on 4/21/14 was to increase the Coumadin to 6 milligrams every day. The revised care plan dated 3/27/14 lacked documentation to indicate the resident received an anti-coagulant medication, Coumadin that had a Black Box Warning (BBW - a medication noted by the Food and Drug Administration (FDA) to have potentially life threatening side effects). According to www.fda.gov, Coumadin contained a Black Box Warning of bleeding risk. Coumadin could cause major or fatal bleeding. Monitor labs regularly in all treated patients. Drugs, dietary changes, and other factors affect International Normalized Ration(INR) levels achieved with Coumadin therapy. On 4/23/14 at 3:45 P.M. observation revealed the resident walked with physical therapy's assistance and used a cane in his/her left hand. Interview on 4/28/14 at 3:00 P.M. administrative licensed nurse D stated he/she expected staff to care plan areas which indicated a potential problem or concern. On 4/29/14 at 2:20 P.M. a telephone call was placed to pharmacy consultant KK and a message was left related to the facility's labeling and monitoring of BBW label medications. Pharmacy consultant KK did not return the call. The facility's consultant pharmacist failed to recognize the facility did not monitor for the	F 428		

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F 428	Continued From page 38 BBWs of Coumadin.	F 428		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		

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F 441	Continued From page 39 This Requirement is not met as evidenced by: The facility reported a census of 98 residents. The sample included 20 residents. Based on observation, record review, and interview, the facility failed to transport clean clothing/linen to prevent the spread of infection on 1 hallway and failed to properly clean two of two observed residents' rooms and bathrooms. Findings included: - Observation on 4/23/14 at 3:32 P.M. revealed an unidentified housekeeping staff member parked a laundry cart on the 400 hallway at the closest end to the nurses' station, picked up about 10 to (-) 12 hangers of clothing and one folded item, proceeded first into a resident's room who the facility identified as having Methicillin-Resistant Staphylococcus aureus (MRSA - a resistant infection) with a sign on the door asking visitors to speak with the nurse prior to entering the resident's room. She/he left off about 3-4 hangers of clothing then went to three more rooms, leaving clothing at each room. Interview on 4/28/14 at 10:28 A.M. with housekeeping staff GG stated housekeeping staff should deliver the clean clothing/linen separately to each resident's rooms. The facility failed to handle clean clothing/linen in a manner to prevent the spread of infection. - Observation on 4/24/14 at 12:59 P.M. house keeping staff HH cleaned a non-isolation resident's room. He/she sprayed a cloth with Dust Spray furniture polish then wiped off the nightstand, dresser, bedside table, and wall	F 441		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 40	F 441		

hangings. The label on the polish did not list it would disinfect or sanitize surfaces. He/she sprayed a cloth with Oasis 299 heavy duty bathroom cleaner and disinfectant, and then wiped down the window blinds and the resident's telephone, and then wiped the surfaces dry. At 1:13 P.M. he/she poured Clorox toilet bowl cleaner in the toilet bowl and cleaned the toilet bowl with the toilet bowl brush he/she had on the housekeeping cart. He/she then sprayed the mirror with Oasis 255 glass cleaner and wiped it dry, then wiped down the sink with the same cloth used for the mirror. At 1:16 P.M., he/she wiped the toilet seat and inside of the toilet rim, then preceded to wipe the base of the toilet and surrounding floor on both sides with the same cloth. He/she used the Clorox toilet bowl cleaner to clean the shower floor and walls. He/she wore the same pair of gloves during the entire room cleaning.

On 4/24/14 at 1:40 P.M. house keeping staff HH cleaned a resident's room who the facility identified as a resident in isolation. He/she sprayed the cloth with Oasis 299 Heavy Duty Bathroom Cleaner and Disinfectant then wiped the toilet seat lid, seat, which was visibly soiled, then wiped the inside of the rim and the sides of the toilet to the floor and surrounding area with the same cloth. At 2:05 P.M. he/she wiped down the shower chair arms with Clorox wipes then 25 seconds later wiped it off with a dry towel. He/she used a Clorox wipe and wiped down the safety bar by the toilet then immediately wiped it dry with a dry towel. He/she used the same toilet bowl brush from the house keeper's cart to clean the toilet bowl then returned it to the housekeeping cart. He/she did not change gloves until he/she left the room after cleaning the isolation room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175517	A. BUILDING _____ B. WING _____	05/02/2014

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SWEET LIFE AT BROOKDALE PLACE	12000 LAMAR OVERLAND PARK, KS 66209

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F 441	Continued From page 41 On 4/24/14 at 1:40 P.M. house keeping staff HH said he/she used Clorox Bleach germicidal wipes in the isolation room and surfaces stayed wet for less than 9 seconds because he/she wiped surfaces dry right away. He/she said he/she did not know the kill times of the disinfectant products used. He/she said he/she used the same toilet bowl brush for all the residents' rooms, whether they were or were not in isolation. He/she said the furniture polish did not disinfect or sanitize surfaces. On 4/24/14 at 2:18 P.M. house keeping staff GG stated all products kill times were a few minutes and the facility used the same toilet bowl brush in all the rooms, including the isolation rooms. On 4/28/14 at 3:26 P.M. administrative staff D stated he/she expected the housekeepers to follow the isolation room cleaning policy and to use a different cloth to clean the rim of the toilet, then get a different cloth to continue cleaning the base of the toilet. He/she did not expect the house keepers to use the same toilet bowl brush in all the rooms, especially if it was used in an isolation room. The facility's policy for Resident Room Cleaning dated August 2013 revealed staff would prepare disinfectant according to manufacturer's recommendations, and clean horizontal surfaces (for example: bedside tables, and overbed tables) daily with a cloth moistened with disinfectant solution. The facility failed to clean residents' rooms in a manner to prevent the spread of infection.	F 441		
F 464 SS=E	483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS	F 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 464	Continued From page 42 The facility must provide one or more rooms designated for resident dining and activities. These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities. This Requirement is not met as evidenced by: The facility identified a census 98 residents. Based on observation and interview the facility failed to provide the residents with sufficient space for dining in 1 of 4 dining rooms on 1 of 4 days on site of the survey. Findings included: - Observation on 4/22/14 at 11:58 A.M. in the Piedmont 2 dining room, staff could not get one resident in a reclining modified wheelchair up to the table. Staff placed the resident beside the table in a way the resident could not reach his/her drinks unassisted. Observation on 4/22/14 during the noon meal in the Piedmont 2 dining room, staff positioned a resident in a reclining wheelchair in a way that he/she was not up to the table and had to move this resident after getting him/her placed at the table to fit another resident at the table. Staff ran the second resident into this resident's legs. Interview on 4/28/14 at 3:39 P.M. with direct care staff PP revealed space was an issue in the dining room and staff had trouble getting some residents up to the table, as the resident's wheelchairs were taller than the table. Interview on 4/28/14 at 3:22 P.M. with licensed	F 464		

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F 464	Continued From page 43 nursing staff L revealed at times staff had to move residents to get other residents in or out of the dining room and could not get some residents up to the table because of the height of the table or size of the wheelchair. Interview on 4/28/14 at 3:50 P.M. with administrative nursing staff D revealed if staff had trouble getting residents up to the tables in the dining room the table heights were adjusted or a bedside table was used to meet the resident's needs. The facility failed to provide a policy about seating and accommodation in the dining room. The facility failed to provide the residents with sufficient dining accommodations.	F 464		